NHS
Dartford Gravesham and Swanley
Clinical Commissioning Group

Meeting:	**Kent Health and Wellbeing Board**
Date of Meeting:	**26th March 2014**
Title of Report:	**Dartford, Gravesham and Swanley CCG 2 Year Operating Plan**
Reporting Officer:	**Patricia Davies – CCG Accountable Officer**

This paper is for ***(Please annotate)***							
Assurance	x	Agreement	x	Discussion		Note for Information	

Executive Summary:

(Please annotate comments / recommendations of sub-committee, if appropriate)

The following report aims to provide an outline of the key programmes within the CCGs Commissioning Plan for 2014/15 to 2015/16.

From 1st April 2013 Dartford, Gravesham and Swanley Clinical Commissioning Group became a statutory body responsible for commissioning health services on behalf of the population of Dartford Gravesham and Swanley. The establishment of the CCG has enabled our local GPs, who understand the health needs of our patients, to influence and monitor how our resources are spent on improving the health of the Dartford, Gravesham and Swanley population. In addition we have agreed a strategic alliance between both Medway CCG and Swale CCG as a North Kent System, to support the transformational system wide change that is required to deliver improved quality and care for our patients within the ever challenging financial envelope. We have also developed a strong strategic partnership with Swale CCG that includes the sharing of both management and clinical resources.

Commissioning is the process of assessing heath needs, funding health services that meet those needs and of monitoring the quality and performance of the services that are provided. Dartford, Gravesham and Swanley CCG aims to clinically lead the commissioning of high quality, safe and effective health services for our local residents and we believe that using our local clinical experts in leading the planning and delivery of high quality healthcare, that we can make a real difference to people's lives.

This commissioning plan indicates what the key priorities are for the period of 2014 and beyond. It incorporates the views of the public, our providers as well as Social Care and Local Authority stakeholders, and is in line with the Health and Wellbeing Strategy to which we have contributed with our key local authority partners. Based on the information we have received through the processes mentioned above, these priorities include making sure that all groups in the population have equal access to high quality services as close to home as possible, improving integrated working between our providers to deliver real patient centred care, continuously increasing the quality of healthcare services for optimum patient experience and ensuring best value for money.

In line with the current health needs of our local population, outlined within the JSNA, and based on the expected increase in the local population, our plan includes a number of key actions:

- Implementing a programme to identify and provide focussed support for those groups of people most at risk of developing, or potentially with undiagnosed, long term conditions. Thereby reducing the health inequalities between the least and most deprived areas of our CCG
- A transfer of care from the acute setting to a community setting:
    - Moving to a prevention / self-management model of care for people with long term conditions,
    - Providing support for people via their GP and health and social care integrated teams, with swift access to expert intervention to support episodes of crisis
    - Ensuring patients are transferred to the most appropriate setting of care for their needs, reducing unnecessary stay in hospital
    - Including for patients with mental health issues who no longer need secondary care input, people with long term conditions including dementia and children.
- Enabling acute care providers to focus on patients suffering acute episodes of ill health, or requiring planned surgery.

This is an exciting but challenging time for us all, but by working together we can make a difference and improve our local health services and health outcomes for our population.

Proposal and / or Recommendation

The Health and Wellbeing Board is asked to:

- Note the key elements of the Operating Plan.
- AGREE the proposed actions and levels of ambition against the
- Note the actions taken to:
    - ensure plans reflect the JSNA and Health and Wellbeing Strategy
    - engage with a variety of stakeholders including local Health and wellbeing Boards
    - Reflect the health and Social Care Integration – as per the Integration Pioneer and Better Care Fund work.

Development of the CCG Two Year Operating Plan

1. Background:

In line with national guidance for the development of NHS Strategic and Operational plans as described in 'Everyone Counts: Planning for Patients 2014/15 to 2018/19', Dartford, Gravesham and Swanley Clinical Commissioning Group has developed its two year Operational Plan, to:

- Meet the needs of the local population, as outlined within the Joint Strategic Needs Assessment, and agreed within the local Health and Wellbeing Board
- Deliver high quality care,
- Reflect integrated commissioning plans across health and social care
- Deliver the aims of the Health and Wellbeing Strategy
- Address issues identified with, and feedback from, our patients, public, GPs, healthcare providers, Social Care and local authority partners, and the voluntary sector.
- deliver the NHS England vision and ambitions, as summarised in the diagram below:

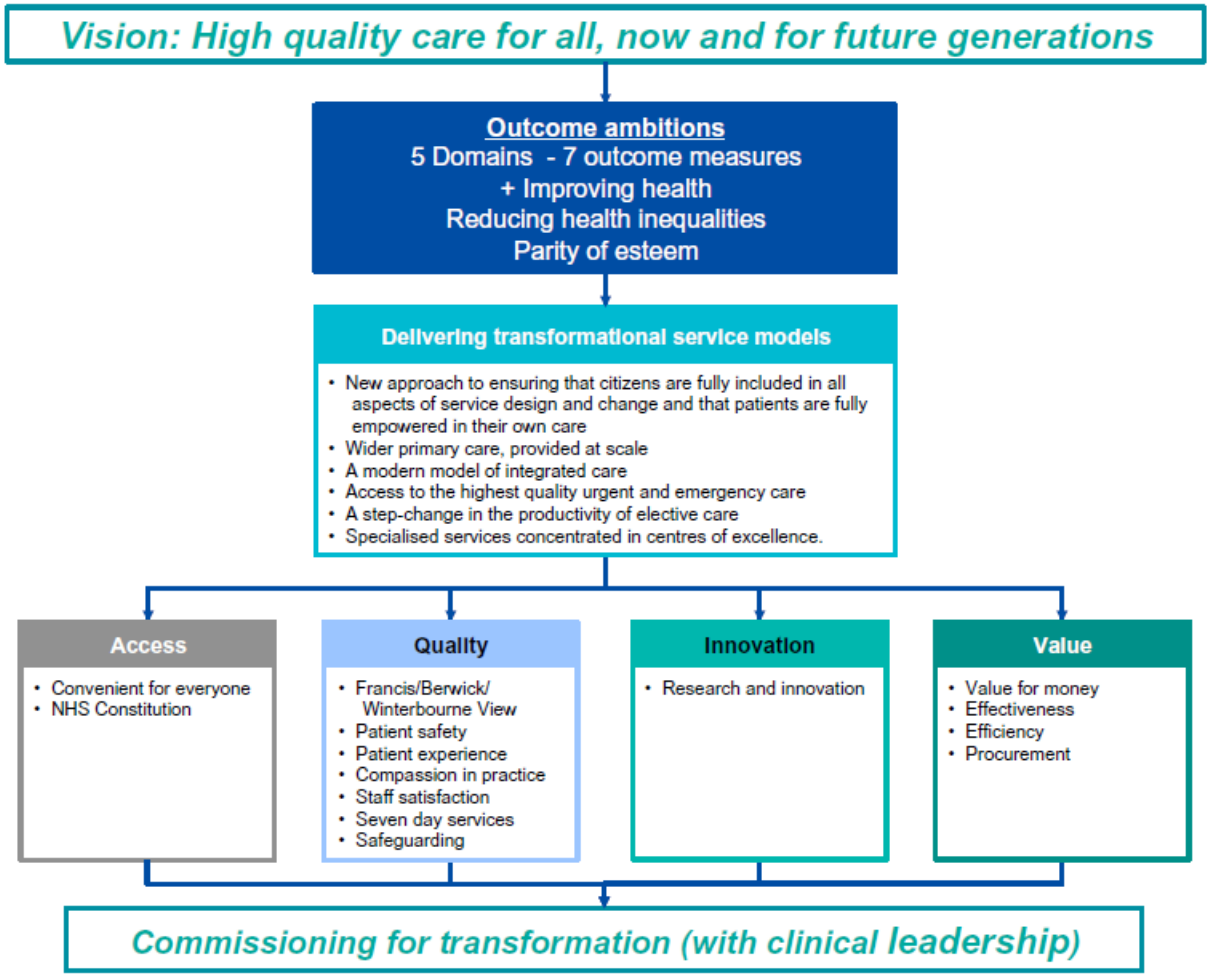
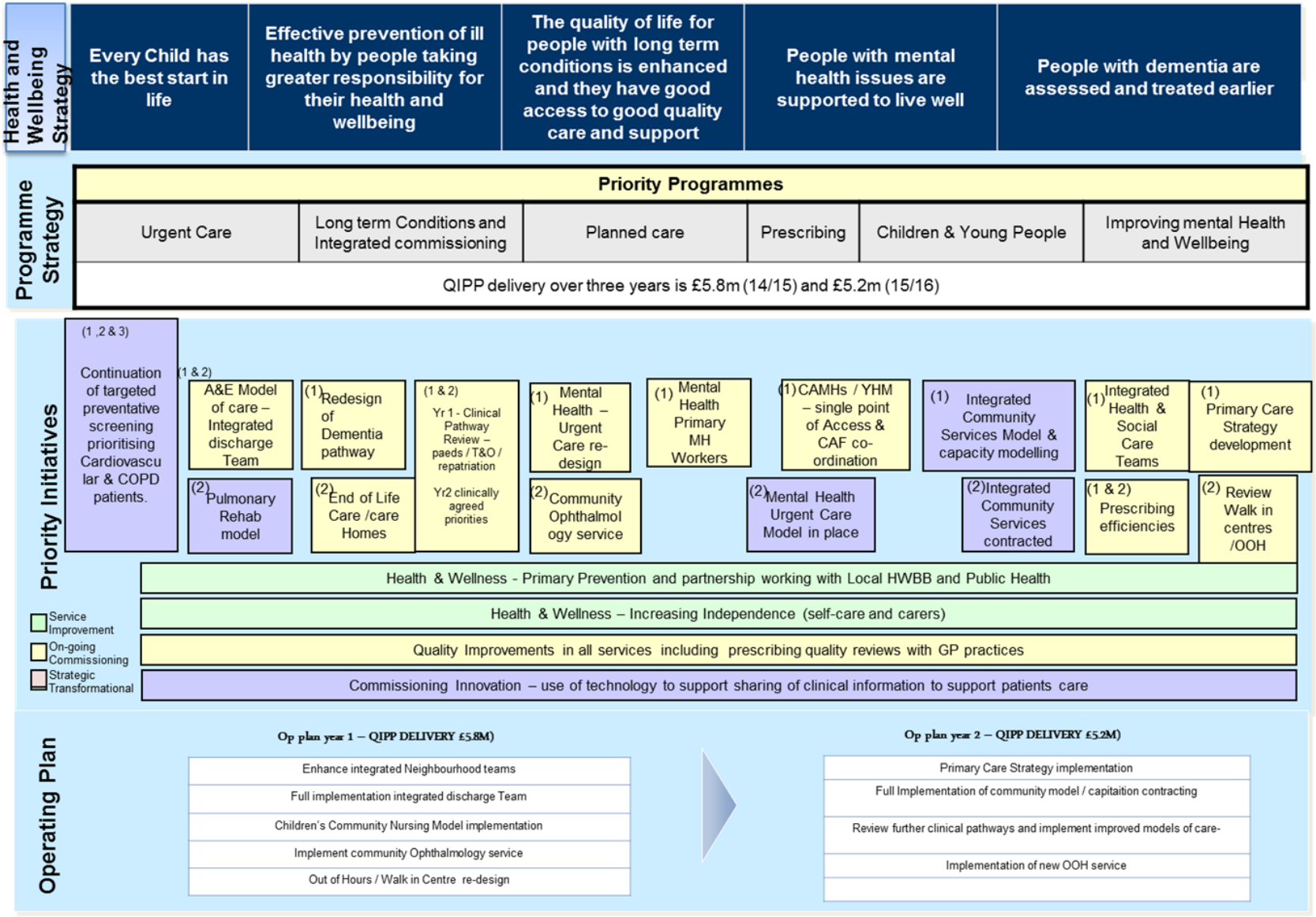


Figure 1: Extract from 'Everyone Counts: Planning for Patients 2014/15 to 2018/19

The following diagram outlines the CCGs key priorities for 2014-2016, linked to the Health and Wellbeing Strategy priorities

NHS DGS CCG 2014-2016



2. Our Vision for 2016

Our vision is to be a clinically led and innovative commissioning organisation that puts patients first, improves their healthcare outcomes, and operates with minimal bureaucracy.

Key within the CCGs clinical vision is to:

- Ensure the healthcare system works better for patients, with a focus on right care, right time, right place, providing seamless, world class, integrated care for patients, particularly with complex needs
- Safeguard vital services, prioritising patients' with the greatest health needs and ensuring that there is clinical evidence behind every decision.
- Improve or maintain quality whilst making efficient use of available resources.
- More care closer to home
- Practices feel that they have been supported in the process of improving care
- Patients and the community take responsibility for their care

This vision cannot be delivered in isolation by the CCG, but requires a whole system approach to the delivery of care. The proposed commissioning intentions outlined within this plan, therefore, reflect the joint view and intentions from the Health Economy developed through partnership forums and clinically led workshops with providers.

This vision is set in the context of the CCGs longer term 5 year vision and Better Care Fund plans, to provide care and support to the people of North Kent (Swale and DGS) in their homes and in their communities. We want to achieve a health economy that is sustainable for the future. Our vision is of primary, community, mental health and acute care services working seamlessly together, with local authority, voluntary, and other independent sector, organisations, to deliver improvements in both health and well-being for local people and communities.

3. The Case for Change

An ageing population and increased prevalence of chronic diseases requires health services to move from the current emphasis on acute and episodic care, towards prevention, self-care, more consistent standards of primary care and care that is well co-ordinated and integrated.

In addition there is the need to:

- Meet increasing clinical need and patient expectations
- Achieve strong performance from our providers tailored to the local population
- Increase efficiency of services and value for money
- Give people choice and control
- Ensure local services and interventions are effective
- Provide systematic and pro-active management of chronic disease within primary care to contribute to reducing health inequalities
- Commission more integrated models of care in order to improve the quality of care for patients and reduce waste.
- Consider prioritising the integration of mental and physical health care more closely as a key part of its strategy to improve quality and productivity in health care.

As mentioned above, the NHS is subject to increasing financial constraints, especially in the current economic climate. Therefore we will need to review how services are provided and how they link up with

other services such as social care to develop the most optimum pathways designed around the needs of our patients. Only by reducing inefficiencies and duplication will we be able to provide the best possible services for the funding available to our population.

In order to deliver on the above, we need to work very closely with both the patients and the public in DGS CCG, as well as the providers of services, and organisations in the voluntary (third) sector.

We will also need to have an on-going conversation with the population of DGS so that we create an increasing awareness and understanding of the things everyone can do to prevent illness. If we can enhance everyone's sense of responsibility for their own health and that of their families, we can not only tackle some of the most intractable health issues, but also prevent significant suffering, and deliver more and better quality services for our population. Our approach to engagement with the public is outlined in section 7.

The NHS Mandate is structured around five key areas where the Government expects the NHS Commissioning Board to make improvements:

- preventing people from dying prematurely
- enhancing quality of life for people with long-term conditions
- helping people to recover from episodes of ill health or following injury
- ensuring that people have a positive experience of care
- treating and caring for people in a safe environment and protecting them from avoidable harm.

3.1 Transformational Change

The need for transformational, system wide change is clearly recognised, and as such, is a key element of the CCG plans going forward. Following feedback from our member practices a review of community services was implemented during 2013. In order to fully identify the key issues, and develop sustainable, transformational change a review of acute and community services across North Kent was undertaken. This work has commenced with an audit by The Oaks Group, followed by stakeholder workshops facilitated by the Kings Fund, in November 2013 and February 2014.

For DGS, the review identified that:

- Up to 38% of adult admissions could have been avoided:
  - 64% were due the consultant related issues
  - 58% of acute admissions could been avoided by providing a variety of services at home.
  - 15% of acute admissions could have been provided for on sub-acute (e.g. community) wards.
  - Additionally, 8% of all admissions required supported living environments.
- 65% of the continuing stay days were avoidable
  - 36% due to discharge planning issues.
  - 37% of continuing stay days could have been avoided by providing a variety of services at home.
  - Additionally, 24% of continuing stay days required were supported living environments.
- For paediatric patients 32% of admissions and 45% of continuing days of stay could have been avoided.

The agreed areas of focus, and plans – including KPIs, milestones, and system wide impact – have been used to underpin commissioning plans for 2014-16 and beyond, as well as the development of the Better Care Fund proposal.

One of the key elements agreed following this review is the need, and potential, to reduce non-elective admissions by:

- 10% in 2014/15, equating to 2,672 admissions, or £4.662m
- With a further 5% reduction in 2015/16 equating to 1,180 admissions and £2.063m
- i.e. a reduction of 3,853 admissions at a cost of £6.725m over two years.

This level of change in admissions is only possible by true integration across health and social care providers, and therefore the North Kent proposals for the Better Care Fund underpin delivery of this operating plan.

3.2 Integrated Care:

The Joint Health and Well Being Strategy identifies integrated commissioning as a key priority and to support the delivery of this, Kent County Council and the CCG have developed a North Kent Strategic Commissioning Group to enable review and discussion of services that could be improved for patients and clients through integration. This aligns with the Integration Pioneer agenda for Kent, and will involve the CCGs GP Clinical leads (from Swale and Dartford, Gravesham and Swanley CCGs) and senior KCC and CCG managers to enable the development of a clear plan on how this will be developed to achieve improved outcomes for our patients/ clients and to monitor the impact of the current services that are being jointly funded.

The key integration projects outlined within the Better Care Fund for 2014/15 are:

- **Integrated Discharge Team model expansion** – to ensure that patients receive the treatment they need and are rapidly discharged with health, social and voluntary sector care and housing support to return back to independent living.

- **Integrated Primary Care teams** – GPs will be at the centre of organising and coordinating people's care. We will invest in primary care, through the reconfiguration of enhanced services and the secondary to primary care shift / shared-care and funding arrangements with other providers. We will ensure that patients can get GP help and support in a timely way and via a range of channels, including email and telephone-based services. The GP will remain accountable for patient care, but with increasing support from other health and social care staff to co-ordinate and improve the quality of that care and the outcomes for the individuals involved. The integrated primary care teams will be based around the General Practice networks and focused on the needs of patients. They will deliver robust rapid response where this is appropriate, long term condition management, geriatrician, mental health, social and voluntary sector care, equipment and housing support. They will actively support GP practices to identifying people who are at risk of admission to hospital or residential / nursing home care where indications are that, with some immediate intensive input, equipment and support, such admissions can be avoided.

- **Integrated Dementia service** within the community and rapid response teams to prevent unnecessary attendance to acute care and facilitate timely and appropriate discharge where an episode of acute care is required.

- **Access to records** – a shared IT infrastructure and record is seen as an enabler to achieve the above. This work has been commenced and a full timeline for implementation is being developed.

3.1. Key Programmes:

Our key programmes are based on addressing issues or areas of concern identified through:

- Health outcomes data
- The Joint Strategic Needs Assessment
- Patient feedback
- Service review – through the Kings Fund / Oak Group work.

The following table aims to summarise the issues identified for Dartford, Gravesham and Swanley population and the key actions we have identified within our commissioning plans:

Health Issue	Key actions being taken
• Higher potential years of life lost[1] • Prevalence of hypertension and hyperthyroidism[1] • Prevalence of chronic kidney disease[1] • Proportion of people with long term conditions feeling supported to manage their condition[1] • Incidence of CVD	Development of: 1. Health inequalities programme aiming to reduce the variation in health across the CCG, and provide focussed support to ensure the early identification of people at risk of developing, or with, long term conditions reducing incidence of complications such as chronic kidney disease in people with diabetes. 2. Integrated primary care team to provide support to patients, particularly those with long term conditions, to more effectively manage their condition; this is linked to the Better Care Fund to support integration across health and social care. In addition, we are working with Public Health and the Health and Wellbeing Board to review wider health issues for our local population, and identify key actions.
• The need for improved communication between health and social care providers; and greater integration of care • Identified reduction in emergency admissions to acute care and length of stay in	Feedback from patients identified the need to improve communications – both between health and social care teams; but also to enable people with long term conditions to manage their health more effectively. This feedback underpins the Better Care Fund projects summarised in section 3.2.

hospital	
• Patient experience of GP OOH services	Service model being developed during 2014/15 for a new service to commence in 2015/16 – the model will be developed based on insight from our patients and GPs
• Incidence of Cancer and Cardiovascular disease	We are working with the Strategic Clinical Networks to review local service provision and identify key actions. Early identification remains a significant aspect of this work.
• Endocrine, nutritional and metabolic problems	For DGS CCG, diabetes remains a significant issue – and work continues to further develop the care pathway, including ensuring education provision and support for patients (links with the development of Integrated Primary Care Teams as outlined in section 3.2)
• Emergency admissions for children	Development of a Community Children's Nursing Service to ensure children and young people receive the right care in the right setting for their needs
• MRSA	This remains an area of focus for our Quality and Safety Team who are working with all providers to minimise the incidence of MRSA and *C difficile*

[1] denotes performance in comparison with England data.

4. Outcomes Indicators:

The national planning guidance - 'Everyone Counts: Planning for Patients 2014/15 to 2018/19 - outlined a number of key ambitions for the NHS in relation to the delivery of health improvements for local people and ensuring the delivery of:

- **An outcomes focused approach**, with stretching local ambitions expected of commissioners, alongside credible and costed plans to deliver them

We have therefore reviewed the current level of performance and have outlined the improvements we expect to deliver during 2014/15 and 2015/16, which is also aligned to our expectations for the impact of plans over the next five years to 2018/19. The following diagrams summarise these expectations, and the projects identified to deliver these levels of ambition:

1. reducing potential years of lives lost through causes considered amenable to healthcare and addressing locally agreed priorities for reducing premature mortality

Projects

- review of health inequalities across the CCG, aiming to prevent incidence, or enable early detection and treatment of key conditions, including dementia
- enhancement of integrated neighbourhood teams
- further development of telehealth / telemedicine
- development of integrated childrens community nursing service

Measures

- reduce gap in life expectancy across the CCG
- prevalence of key conditions

Impact

- Potential years of life lost rate per 100,000 to reduce by 4.6% (from a baseline of 1946.9 to 1857.3) *NB this reduction is currently based on national guidance - local data currently under review to confirm levels of ambition*

2. Reducing avoidable emergency admissions

Projects

- redesign of the emergency pathway, including consultant presence in A&E 24/7 and pathways for redirection to community teams
- enhancement of integrated neighbourhood teams, and implementation of a named healthcare professional and care plan for patients with LTCs
- development of integrated childrens community nursing service

Measures

- reduction in emergency admissions and readmissions
- reduction in length of stay in acute care

Impact

- reduce emergency admissions by a total of 15% over two years
- links with the emergency admissions compostie indicator - move from current baseline (2070.1) to the next (improved) quartile range over 5 years.
- 2014/15 targets
- Q1 2014/15 = 2055.2
- Q2 2014/15 = 2040.4
- Q3 2014/15 = 2025.5
- Q4 2014/15 = 2010.6

3. improving access to psychological therapies;

Projects

- Continued implementatoin of talking therapies

Measures

- The proportion or people who have received psychological therapies out of the total numbe of people who have depression and / or anxiety disorders

Impact

- achieving 15% target by the end of 2014/15 (total of 3,330 people receiving psychological therapy):
- via treating 765 people per quarter (3.5%)

4. Demonstrating Improvement in patient experience: addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in 2014/15 and showing improvement in a locally selected patient experience indicator

Projects

- ongoing review of clinical pathways including dermatology and ophthalmology
- implementation of telephone follow up appointments
- development of 7 day services
- Implementing dementia support workers within the Integrated Discharge Team

Measures

- NHS Constitution access targets achieved
- Friends and family test

Impact

- achievement of national target for friends an dfamily test
- *locally determined indicator*

5. improving the reporting of medication-related safety incidents based on a locally selected measure

Projects	• ongoing assurance of providers incident reporting processes and identification of themes and trends in incidents.
Measures	•*currently being finalised*
Impact	• *locally determined indicator*

6. The number of multidisciplinary care plans in place for people with dementia

Projects	• implementeation of Specialist Dementia Teams as outlined in the Better Care fund, linked with the Integrated Primary Care Teams and GPs / Social Care / dementia
Measures	•The number of people with a care plan as a proportion of the expected total number of patients diagnosed.
Impact	• 75% of people with dementia to have a care plan in 2014/15 - therefore enabling coordinated care impacting on both health outcomes for the individual and patient / carer experience. •The North Kent Better Care Fund aims for 90% of people with dementia to multidisciplinary care plan; for 2014/15 this is set at 75% acknowledging the time for implementation of the above teams.

In order to ensure that these indicators addresses and aligns with the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy, the Kent Health and Wellbeing Strategy is asked to comment and approve on the above levels of ambition.

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5. Development of Plans

The following table aims to provide assurance on the development of the Operating Plan against key criteria:

Evidence of links to Pioneer and BCF	The Operating Plan recognises the key role integration between health – including primary, secondary and community care – and social care as key to delivering improved care pathways, reducing system inefficiency and, most importantly, improving health outcomes and patient / carer experience. The Better Care Fund – and therefore Pioneer plans – forms the core of our plans for the next two to five years.
Assurance that scrutiny by local HWBs has been carried out	Commissioning plans have been presented to the Dartford, Gravesham and Swanley board on an ongoing basis over recent months. In addition, plans have been shared at subgroups of the Board enabling input from a variety of stakeholders.
Evidence of compatibility with the HWBS and JSNA	The basis for the development of the Operating Plan is the JSNA and Health and Wellbeing Strategy. This is evidenced within the Operating Plan via: 6. Plan on a Page for 2014/15 to 2015/16 (see page 4) 7. Summary of governance arrangements with the Health and Wellbeing Board outlining links with the Health and Wellbeing Strategy 8. Outline of the local health needs

Evidence it has been discussed with a range of stakeholders	Stakeholder engagement forms an important aspect in the ongoing review and development of health services. In addition to public events – at which local authority, health care provider, social services and voluntary sector providers are also invited – we have undertaken a number of actions to ensure we share, and gather feedback on, plans – this remains an ongoing process and continues throughout the commissioning process. Discussions may focus on specific elements of plans e.g. integration or urgent care; or the plan in its entirety e.g. public event held February 2014. Examples of forums for discussion with stakeholders include: Through existing governance frameworks: • Executive Programme Boards – Social Care, health care providers and commissioner (including Bexley CCG) • Programme Delivery groups – social care, health care providers and commissioners • Protected Learning Time events with GPs and practice nurses • County and local Health and Wellbeing Boards and subgroups Through events or dedicated sessions: • Better Care Fund – workshops with GPs, healthcare providers and commissioners, Social Care • Kings Fund workshops - workshops with GPs, healthcare providers and commissioners, Social Care • Voluntary sector events – April 2013, October 2013 and planning for next event in Q1 2014/15 • Public Events held July 2013 and February 2014 – as well as working with local Patient Participation Groups and their Chairs to share information and seek feedback.

9. Recommendations

The Health and Wellbeing Board is asked to:

- Note the key elements of the Operating Plan.
- AGREE the proposed actions and levels of ambition against the Outcomes Indicators outlined in section 4.
- Note the actions taken to:
    - ensure plans reflect the JSNA and Health and Wellbeing Strategy
    - engage with a variety of stakeholders including local Health and wellbeing Boards
    - Reflect the health and Social Care Integration – as per the Integration Pioneer and Better Care Fund work.